| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section and the Durham County Department of Social Services conducted a follow-up survey and a complaint investigation on May 10, 2022 to May 12, 2022. | {D 000} | | |
| D 230 | 10A NCAC 13F .0702 (f) Discharge Of Residents<br><br>10A NCAC 13F .0702 Discharge Of Residents<br><br>(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:<br>(1) notifying staff in the county department of social services responsible for placement services;<br>(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;<br>(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and<br>(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:<br>(A) a copy of the resident's most current FL-2;<br>(B) a copy of the resident's most current assessment and care plan;<br>(C) a copy of the resident's current physician orders;<br>(D) a list of the resident's current medications;<br>(E) the resident's current medications;<br>(F) a record of the resident's vaccinations and TB screening;<br>(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule: | D 230 | Administrator and/or designee will notify county monitor immediately when discharge of resident is imminent. 6/9/22<br><br>Administrator and/or designee will notify resident and/or responsible party why discharge is necessary. 6/9/22<br><br>HWD and/or designee will collaborate with new placement to provide copy of residents FL2, assessment, care plan, physician orders, medication list, vaccinations, TB, 6/9/22<br><br>Administrator and/or designee will provide resident written notice discharge 6/9/22<br><br>Administrator and/or designee will notify ombudsman. 6/9/22 | |


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Bell Administrator — TITLE — (X6) DATE: 6/16/22





Reviewed and Acknowledged. 06/27/22 P.D

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 1<br>(A) the regional long term care ombudsman; and<br>(B) the protection and advocacy agency established under federal law for persons with disabilities.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to provide a safe and orderly discharge for 1 of 1 sampled resident (Resident #6) who was discharged without proper notification.<br><br>The findings are:<br><br>Review of Resident #6's current FL-2 dated 09/29/21 revealed:<br>-Diagnoses included Alzheimer's disease, hypertension, osteoarthritis, chronic kidney disease, chronic pain, and macular degeneration.<br>-The level of care was special care unit (SCU).<br><br>Review of a second FL-2 for Resident #6 dated 05/03/22 revealed:<br>-It was signed by a primary care provider (PCP).<br>-Diagnoses included advanced dementia, chronic kidney disease, chronic pain and macular degeneration.<br>-Resident #6 was verbally abusive.<br>-The recommended level of care was skilled nursing facility (SNF).<br><br>Review of Resident #6's Resident Register revealed:<br>-Resident #6 was admitted on 09/25/21.<br>-The notice of discharge was dated 05/02/22.<br>-The Administrator was checked off as initiating the discharge.<br>-The reason section noted the resident was sent to the emergency room (ER) and involuntary discharged from the facility. | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 2<br>-The date of the discharge was 05/04/22 and it was noted Resident #6 discharged to the named local hospital.<br>-The discharge was signed by the Administrator and the Power of Attorney (POA).<br><br>Review of Resident #6's progress notes from 12/03/21 to 05/02/22 revealed:<br>-On 12/03/21 Resident #6 hit another resident; Resident #6 had a small cut to his arm.<br>-Resident #6 and the other resident were separated; no PRN (as needed) medications were given.<br>-On 12/07/21 a resident attacked Resident #6 and Resident #6 had a swollen eye.<br>-On 12/30/21 Resident #6 hit another resident; the POA was notified, and a care conference was scheduled to discus behaviors and a plan of care.<br>-On 01/25/22 Resident #6 grabbed a resident as they walked by him; EMS was notified and evaluated, and he was calm at the time.<br>-On 05/02/22 Resident #6 struck out at a resident; staff had stated Resident #6 was agitated earlier in the day and his PRN was administered prior to him striking out at the other resident.<br><br>Review of a hospital note for Resident #6 dated 05/03/22 revealed:<br>-The note was completed and signed by a physician at the hospital.<br>-The facility called the local emergency medical service (EMS) to transport Resident #6.<br>-Resident #6 was brought to the emergency department (ED) on 05/02/22 due to aggressive behavior.<br>-Resident #6 was ready for discharge from the hospital.<br>-Resident #6 had difficult placement issues as he apparently would not be able to return to his | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 3<br>current Assisted Living Facility (ALF).<br>-Attempts to discharge Resident #6 back to the facility did not work out so he was admitted to the medical part of the hospital.<br>-Resident #6 had not had behavioral issue since coming to the ED.<br>-He tested positive for a urinary tract infection (UTI) and was treated with intravenous fluids and antibiotics.<br><br>Interview with POA on 05/10/2022 at 11:22am revealed:<br>-She and another family member were both POAs for Resident #6.<br>-Resident #6 was still at the local hospital.<br>-She was trying to get Resident #6 in a SNF.<br>-Resident #6 had severe dementia.<br>-Resident #6 did better when he was not around a crowd of people.<br>-She was told staff did not witness Resident #6 hitting a resident.<br>-EMS was called to the facility.<br>-When EMS arrived, they saw no injuries on Resident #6; Resident #6 was sent to the Emergency Room.<br>-The POAs were not notified until after Resident #6 was in the local hospital.<br>-Case Manager from the Emergency Room contacted her and informed her Resident #6 was in the local hospital and the facility would not allow him back.<br>-The hospital did not see any visual injuries on Resident #6.<br>-The local hospital wanted to send Resident #6 back to the facility.<br>-The facility would not take Resident #6 back.<br>-The facility refused to allow Resident #6 back to come back to the facility.<br>-She did not receive a letter from the facility to inform her of a discharge. | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 4<br>-The hospital informed her that Resident #6 was dehydrated and had an UTI.<br><br>Interview with Resident #6's POA on 05/12/22 at 10:25am revealed:<br>-He was notified .<br>-He was notified by the second shift supervisor on Monday, 05/02/22 at 6:17pm that Resident #6 had a behavioral episode before 3:00pm.<br>-He was notified of the incident after the facility decided to send Resident #6 to the Emergency Department and the incident had been unwitnessed.<br>-Resident #6 was admitted to the hospital because the facility would not allow him to return to the facility.<br>-The second shift supervisor told him Resident #6 would not be allowed to return to the hospital.<br>-He had asked the facility to take Resident #6 back to his room after meals; and not place Resident #6 in the commons area with the other residents.<br>-Resident #6 would become agitated when in a crowd.<br>-Resident #6 had macular degeneration and could not see well; Resident #6 needed to be approached from the front and spoken to while doing so.<br>-He would "act out" and start swinging when others got to close to him, especially if he was startled.<br>-Resident #6 was in the South Pacific during World War II and when awaken from sleep or started he would start swinging.<br>-He met with the management team on Tuesday, 05/03/22.<br>-He was informed at the management meeting the incident was witnessed by the staff and Resident #6 would not be allowed back in the facility. | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 5<br>-Resident #6's belongings were packed and removed from the facility on Wednesday, 05/04/22.<br>-Resident #6 was discharged effective Wednesday, 05/04/22.<br><br>Interview with local hospital Case Manager on 05/10/2022 at 12:45pm revealed:<br>-Resident #6 arrived at the Emergency Room on 05/02/2022.<br>-Resident #6 was still in local hospital as of today, 05/10/22.<br>-She was told by the facility Resident #6 was aggressive.<br>-Resident #6 had not shown any aggression since entering the hospital.<br>-During the arrival of the Emergency Room Resident #6 was calm.<br>-She was not clear what reason was transported to the hospital from the facility.<br>-The facility would not take Resident #6 back.<br><br>Telephone interview with the PCP on 05/12/22 at 10:43pm revealed:<br>-Resident #6 was under hospice care.<br>-He did not regularly care for Resident #6.<br>-He was told by the facility that Resident #6 was transported to the hospital for aggressive behaviors.<br>-It was implied in an email sent to him by the Health and Wellness Director (HWD) on 05/03/22 at 2:00pm that Resident #6 needed a higher level of care and that hospice and the family [POA] agreed with the decision.<br>-He was told in the email that Resident #6 needed a higher level of care because of behaviors and was currently in the hospital due to behaviors.<br>-There had been no discussion of any behaviors with Resident #6 prior to 05/02/22 and no | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 6<br>concerns of a higher level of care for Resident #6 prior to 05/02/22.<br>Telephone interview with the hospice nurse on 05/12/22 at 3:00pm revealed:<br>-She had seen Resident #6 on 05/02/22 and he was calm.<br>-Resident #6 was sitting in the common area watching television.<br>-There had been some behaviors in the past, but his mediations had been adjusted and he was better.<br>-She had been in contact with the family; sometimes the POA would contact her before the facility would when there was a concern with Resident #6.<br>-Resident #6 was under hospice care ; hospice was responsible for any assessments and the medical director from hospice was responsible for signing any FL-2s.<br>-The POA contacted her and asked about Resident #6 being transported and admitted to the hospital.<br>-The hospital informed hospice that Resident #6 was admitted to the hospital on 05/02/22.<br>-She was informed by hospice that Resident #6 was admitted to the hospital and he was not going back to the facility.<br><br>Telephone interview with the Ombudsman on 05/12/22 at 11:08am revealed:<br>-The facility had not reached out to her concerning discharging Resident #6.<br>-The POA contacted her on the morning of 05/03/22 about assisting them with finding a facility for Resident #6.<br>-The POA was having a problem finding a skilled nursing facility that would admit Resident #6 because of the levels of some of his medications and his current FL-2's recommended level of care was special care unit (SCU). | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 7<br>-She visited the facility on 05/04/22 but did not speak to the Administrator.<br>-She contacted the Administrator on 05/06/22 to discuss Resident #6's discharge but could not determine cause and effect.<br>-She thought Resident #6 was still in the hospital.<br><br>Confidential interview with a facility staff revealed:<br>-Proper protocol was not followed the day Resident #6 was sent to the local hospital (05/02/22) because there was a long lapse in time before 911 was called.<br>-Resident #6 was not administered his PRN (as needed) medication after he became agitated.<br>-Resident #6 needed to be redirected when he tried to grab residents and he would calm down.<br>-Resident #6 became very calm after he was separated from the other resident on 05/02/22.<br>-The local EMS did not know why they were being asked to transport Resident #6 to the hospital because the resident was calm when they arrived at the facility.<br>-The hospital called the facility on 05/02/22 and wanted to know why Resident #6 was transported to the emergency department because he was very calm.<br>-The facility staff were instructed by management, if the hospital called to send Resident #6 back to the facility on 05/02/22, to tell the hospital that Resident #6 was being discharged and could not come back to the facility.<br>-The Administrator and the HWD told the facility staff that Resident #6 would not be coming back to the facility and to tell the POA if staff had contact with them.<br><br>Interview with a PCA on 05/12/2022 at 11:15am revealed:<br>-On 05/02/2022 during the shift changing of 1st shift and 2nd shift she heard a resident | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 8<br>screaming.<br>-She had seen Resident #6 in his wheelchair and he was agitated and he was swinging his arms before she heard the resident screaming.<br>-Resident #6 appeared to look angry and was knocking on the wall.<br>-Stated she informed the Memory Care Coordinator at 2:45pm Resident #6 was agitated.<br>-She did not have any other information about 05/02/22.<br><br>Interview with a second PCA on 05/12/2022 at 11:40am revealed:<br>-Resident #6 hit a resident in the arm between 2:45pm and 3:00pm.<br>-She was not sure if the residents went to the hospital.<br><br>Interview with Memory Care Coordinator (MCC) on 05/12/2022 at 9:45am revealed:<br>-She did not see the incident that occurred on 05/02/2022 with Resident #6 and another resident.<br>-She was not in the Memory Care Unit when the incident occurred; she was in the front part of the building.<br>-She heard about the incident from other staff members that was in the SCU.<br>-She did not know what really happened.<br><br>Interview with the second shift supervisor on 05/11/22 at 5:08pm revealed:<br>-Resident #6 loved to talk to other residents and staff, he would sit quietly in the common area or the dining room but would reach out and try to grab or grab residents as they walked by him.<br>-Resident #6 had grabbed a resident by the small of their back and would not let go while in the dining room one evening.<br>-He separated Resident #6 and the other | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 9<br>resident; Resident #6 was calm after that.<br>-Resident #6 would get upset but then could be redirected and would calm down.<br>-He reported to work on 05/02/22 about 3:00pm.<br>-He did not see Resident #6 until about 4:00pm and he was calm and not aggressive or agitated at the time.<br>-He was made aware of the resident to resident aggression between Resident #6 and another resident by a personal care aide (PCA) about 4:45pm.<br>-He was told by the PCA that the incident had occurred around 2:30pm.<br>-The local EMS did not want to transport Resident #6 to the hospital because he was not aggressive or agitated when they responded to the facility.<br>-He was not sure what time Resident #6 was transported to the hospital.<br>-He contacted the POA about 6:00pm to inform them Resident #6 had been transported to the hospital.<br>-He called Resident #6's POA and informed him Resident #6 had been transferred to the hospital and would not be allowed to return.<br><br>Interview with the HWD on 05/12/22 at 8:53am revealed:<br>-Resident #6 had a history of grabbing other residents and pulling them down.<br>-Once Resident #6 would pull a resident down he would hit the resident.<br>-His behaviors had improved, and he did not have any incidents from January 2022 until 05/02/22.<br>-She was not sure of the timeline of the incident on 05/02/22 that involved Resident #6 and another resident.<br>-It was reported to her by the PCA that Resident #6 hit another resident and the resident was crying.<br>-Resident #6 was known to become agitated and | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 10<br>would hum before he became aggressive; sometimes he would "come out of it" after he hummed.<br>-Resident #6 was still agitated when the EMS responded.<br>-The EMS accessed Resident #6 and decided to transport him to the local hospital.<br>-The hospital called the facility on 05/03/22 to discuss sending Resident #6 back to the facility.<br>-The Administrator, the hospital discharge planner, herself and two of Resident #6's POAwere on a group call.<br>-The Administrator informed the POA that Resident #6 was going to be discharged from the facility and that she was initiating a fourteen-day discharge notice due to safety concerns for Resident #6 and other residents.<br>-The Administrator was responsible for discharge paperwork.<br><br>Interview with Administrator on 05/10/2022 at 9:45am revealed:<br>-Resident #6 had hit 4 residents in the SCU.<br>-The facility did not discharge the resident out of the facility.<br>-The family came and took everything out of the facility on 05/04/22.<br>-The facility did not give the family the paperwork for an appeal.<br>-The PCP had said the Resident #6 was not a good fit for this facility.<br><br>Interview with the Administrator on 05/12/22 at 10:18am revealed:<br>-The PCP discharged residents from the facility once they recognized the resident required a need for a higher level of care.<br>-Once the PCP signed a new FL-2 with a higher level of care then the resident would be discharged from the facility. | D 230 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 230 | Continued From page 11<br>-The facility could not discharge a resident to a hospital.<br>-Reasons for discharging residents included behaviors.<br>-The facility would discuss interventions with the physicians and then assist with relocating the resident.<br>-She would notify the Ombudsman and the county Department of Social Services (DSS) of the formal discharge and to help with relocating the resident.<br>-She verbally notified the POAshe was going to start a discharge notice for Resident #6 during a group teleconference with the hospital case worker, the POAand the HWD on the morning of 05/03/22.<br>-She had enlisted the help of the hospital case worker with the relocation of Resident #6 to another facility because she felt the hospital had more resources and contacts in the local area.<br>-She had intentions of bringing Resident #6 back to the facility once he was discharged from the hospital.<br>-The PCP signed the FL-2 dated 05/03/22 to recommend a higher level of care for Resident #6 due to behaviors.<br>-She did not notify the Ombudsman or the county DSS about discharging Resident #6 after he was transported to the local hospital.<br>-In hind site she would have given Resident #6 a thirty-day discharge notice long before the incident on 05/02/22. | D 230 | | |
| {D 358} | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(a) An adult care home shall assure that the preparation and administration of medications, | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 12<br>prescription and non-prescription, and treatments by staff are in accordance with:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observation, interview, and record reviews, the facility failed to administer medications as ordered for 1 of 6 sampled residents (#6) including a medication used to treat elevated blood pressure, two antipsychotic medications, a medication to treat reflux, a medication to treat benign prostate hypertrophy (BPH) and a medication to treat and prevent constipation.<br><br>The findings are:<br><br>Review of Resident #6's current FL-2 dated 09/29/21 revealed diagnoses included Alzheimer's disease, hypertension, osteoarthritis, chronic kidney disease, chronic pain, and macular degeneration.<br><br>a. Review of Resident #6's current FL-2 dated 09/29/21 revealed an order for amlodipine (used to treat elevated blood pressure) 5mg daily.<br><br>Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for amlodipine 5mg daily with a scheduled administration time of 8:00am.<br>-There was documentation that amlodipine was administered daily at 8:00am from 01/01/22 to 0/31/22.<br><br>Review of Resident #6's February 2022 eMAR | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 13<br>revealed:<br>-There was an entry for amlodipine 5mg daily with a scheduled administration time of 8:00am.<br>-There was documentation that amlodipine was administered daily at 8:00am from 02/01/22 to 02/28/22.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 05/12/22 at 9:53am revealed:<br>-Amlodipine was used to treat elevated blood pressure.<br>-There was an order for amlodipine 5mg daily dated 09/29/21.<br>-The pharmacy dispensed 30 tablets of amlodipine 5mg on 01/27/22.<br>-The facility returned 21 of 30 tablets of amlodipine 5mg on 03/07/22 that were dispensed on 01/27/22.<br>-The pharmacy dispensed 30 tablets of amlodipine 5mg on 02/28/22.<br><br>Based on eMAR documentation, medications dispensed and medications returned to the pharmacy between 01/27/22-03/07/22, there would have been no amlodipine available to be administered from 02/06/22-02/28/22.<br><br>Attempted telephone interview with Resident #6's hospice provider on 05/12/22 at 10:00am was unsuccessful.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm.<br><br>Refer to the interview with a medication aide (MA) on 05/12/22 at 1:45pm.<br><br>Refer to the telephone interview with the second | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 14<br>shift supervisor on 05/12/22 at 10:00am.<br><br>Refer to the telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm.<br><br>Refer to the interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm.<br><br>Refer to the interview with the Administrator on 05/12/22 at 4:05pm.<br><br>b. Review of Resident #6's physician's order dated 10/04/22 revealed an order for haloperidol (used to treat agitation and behaviors) 0.5mg, ½ tablet twice daily.<br><br>Review of Resident #6's February 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for haloperidol 0.5mg ½ tablet twice daily with a scheduled administration time of 8:00am and 2:00pm<br>-There was documentation that haloperidol was administered daily at 8:00am from 02/01/22 to 02/28/22.<br><br>Review of Resident #6's March 2022 eMAR revealed:<br>-There was an entry for haloperidol 0.5mg, ½ tablet twice daily with a scheduled administration time of 8:00am and 2:00pm<br>-There was documentation that haloperidol was administered daily at 8:00am from 03/01/22 to 03/31/22.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 05/12/22 at | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 15<br><br>9:53am revealed:<br>-Haloperidol was used to treat anxiety and agitation.<br>-There was an order for haloperidol 0.5mg, ½ tablet twice daily dated 10/04/21.<br>-The pharmacy dispensed 30 tablets of haloperidol 0.5mg on 02/02/22.<br>-The facility returned 13.5 of 30 tablets of haloperidol 0.5mg on 03/07/22 that were dispensed on 02/02/22.<br>-The pharmacy dispensed 30 tablets of haloperidol 0.5mg on 02/28/22.<br><br>Based on eMAR documentation, medications dispensed, and medications returned to the pharmacy between 02/02/22-03/07/22, there would have been no haloperidol available to be administered at 8:00pm on 02/26/22, and at 8:00am and 8:00pm on 02/27/22 and 02/28/22.<br><br>Attempted telephone interview with Resident #6's hospice provider on 05/12/22 at 10:00am was unsuccessful.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm.<br><br>Refer to the interview with a medication aide (MA) on 05/12/22 at 1:45pm.<br><br>Refer to the telephone interview with the second shift supervisor on 05/12/22 at 10:00am.<br><br>Refer to the telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm.<br><br>Refer to the interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm. | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 16<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm.<br><br>Refer to the interview with the Administrator on 05/12/22 at 4:05pm.<br><br>c. Review of Resident #6's a physician's order dated 01/28/22 revealed an order for quetiapine (used to treat anxiety and agitation) 50mg three times daily.<br><br>Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for quetiapine 50mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.<br>-There was documentation that quetiapine was administered at 8:00pm on 01/28/22 and at 8:00am, 2:00pm and 8:00pm from 01/29/22-01/31/22.<br><br>Review of Resident #6's February 2022 eMAR revealed:<br>-There was an entry for quetiapine 50mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.<br>-There was documentation that quetiapine was administered three times daily at 8:00am from 02/01/22 to 02/28/22.<br>-There was an exception documented on 02/27/22 at 2:00pm; the exception was documented as did not administer, resident was sleeping.<br><br>Review of Resident #6's March 2022 eMAR revealed:<br>-There was an entry for quetiapine 50mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 17<br>-There was documentation that quetiapine was administered three times daily at 8:00am, 2:00pm and 8:00pm from 03/01/22-03/31/22.<br><br>Review of Resident #6's April 2022 eMAR revealed:<br>-There was an entry for quetiapine 50mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.<br>-There was documentation that quetiapine was administered three times daily at 8:00am, 2:00pm and 8:00pm from 04/01/22-04/30/22.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 05/012/22 at 9:53am revealed:<br>-Quetiapine was used to treat agitation.<br>-There was an order for quetiapine 50mg three times daily dated 01/28/22.<br>-The pharmacy dispensed 21 tablets of quetiapine 50mg on 01/28/22.<br>-The pharmacy dispensed 90 tablets of quetiapine 50mg on 02/02/22.<br>-The facility returned 19 of 90 tablets of quetiapine 50mg on 03/07/22 that were dispensed on 02/02/22.<br>-The pharmacy dispensed 90 tablets of quetiapine 50mg on 03/02/22.<br>-The pharmacy dispensed 90 tablets of quetiapine 50mg on 03/30/22.<br>-The facility returned 90 of 90 tablets of quetiapine 50mg on 04/18/22 that were dispensed on 03/30/22.<br>-The pharmacy dispensed 90 tablets of quetiapine 50mg on 04/29/22.<br><br>Based on eMAR documentation, medications dispensed and returned to the pharmacy between 02//02/22-04/18/22, there would have been no quetiapine available to be administered from | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 18<br>02/24/22-03/02/22 and 04/02/22-04/28/22.<br><br>Attempted telephone interview with Resident #6's hospice provider on 05/12/22 at 10:00am was unsuccessful.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm.<br><br>Refer to the interview with a medication aide (MA) on 05/12/22 at 1:45pm.<br><br>Refer to the telephone interview with the second shift supervisor on 05/12/22 at 10:00am.<br><br>Refer to the telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm.<br><br>Refer to the interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm.<br><br>Refer to the interview with the Administrator on 05/12/22 at 4:05pm.<br><br>d. Review of Resident #6's current FL-2 dated 09/29/22 revealed an order for omeprazole (used to treat reflux) 20mg daily.<br><br>Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for omeprazole 20mg daily with a scheduled administration time of 8:00am.<br>-There was documentation that omeprazole was administered daily at 8:00am from 01/01/22 to 01/31/22. | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 19<br>-There was documentation on 01/25/22 at 8:00am of an exception; the resident was out of the facility.<br><br>Review of Resident #6's February 2022 eMAR revealed:<br>-There was an entry for omeprazole 20mg daily with a scheduled administration time of 8:00am.<br>-There was documentation that omeprazole was administered daily at 8:00am from 02/01/22 to 02/28/22.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 05/12/22 at 9:53am revealed:<br>-Omeprazole was used to treat reflux.<br>-There was an order for omeprazole 20mg daily dated 09/29/21.<br>-The pharmacy dispensed 30 tablets of omeprazole 20mg on 01/27/22.<br>-The facility returned 26 of 30 tablets of omeprazole 20mg on 03/07/22 that were dispensed on 01/27/22.<br>-The pharmacy dispensed 30 tablets of omeprazole 20mg on 02/28/22.<br><br>Based on eMAR documentation, medications dispensed and returned to the pharmacy between 01/27/22-03/07/22, there would have been no omeprazole available to be administered from 02/02/22-02/28/22.<br><br>Attempted telephone interview with Resident #6's hospice provider on 05/12/22 at 10:00am was unsuccessful.<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm. | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 20<br>Refer to the interview with a medication aide (MA) on 05/12/22 at 1:45pm.<br><br>Refer to the telephone interview with the second shift supervisor on 05/12/22 at 10:00am.<br><br>Refer to the telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm.<br><br>Refer to the interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm.<br><br>Refer to the interview with the Administrator on 05/12/22 at 4:05pm.<br><br>e. Review of Resident #6's current FL-2 dated 09/29/21 revealed an order for tamsulosin (used to treat benign prostate hypertrophy) 0.4mg at bedtime.<br><br>Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for tamsulosin 0.4mg at bedtime with a scheduled administration time of 8:00pm.<br>-There was documentation that tamsulosin was administered daily at 8:00pm from 01/01/22 to 01/31/22.<br><br>Review of Resident #6's February 2022 eMAR revealed:<br>-There was an entry for tamsulosin 0.4mg at bedtime with a scheduled administration time of 8:00pm.<br>-There was documentation that tamsulosin was administered daily at 8:00pm from 02/01/22 to | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 21<br>02/28/22.<br><br>Review of Resident #6's March 2022 eMAR revealed:<br>-There was an entry for tamsulosin 0.4mg at bedtime with a scheduled administration time of 8:00pm.<br>-There was documentation that tamsulosin was administered daily at 8:00pm from 03/01/22 to 03/31/22.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 05/12/22 at 9:53am revealed:<br>-Tamsulosin was used to treat benign prostate hypertrophy.<br>-There was an order for tamsulosin 0.4mg at bedtime dated 09/29/21.<br>-The pharmacy dispensed 30 tablets of tamsulosin 0.4mg on 01/27/22.<br>-The facility returned 8 of 30 tablets of tamsulosin 0.4mg on 03/07/22 that were dispensed on 01/27/22.<br>-The pharmacy dispensed 30 tablets of tamsulosin 0.4mg on 02/28/22.<br>-The facility returned 9 of 30 tablets of tamsulosin 0.4mg on 04/05/22 that were dispensed on 02/28/22.<br>-The pharmacy dispensed 30 tablets of tamsulosin 0.4mg on 03/30/22.<br><br>Based on eMAR documentation, medications dispensed and returned to the pharmacy between 01/27/22-04/05/22, there would have been no tamsulosin available to be administered from 02/18/22-02/28/22 and 03/22/22-03/30/22.<br><br>Attempted telephone interview with Resident #6's hospice provider on 05/12/22 at 10:00am was unsuccessful. | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 22<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm.<br><br>Refer to the interview with a medication aide (MA) on 05/12/22 at 1:45pm.<br><br>Refer to the telephone interview with the second shift supervisor on 05/12/22 at 10:00am.<br><br>Refer to the telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm.<br><br>Refer to the interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm.<br><br>Refer to the interview with the Administrator on 05/12/22 at 4:05pm.<br><br>f. Review of Resident #6's current FL-2 dated 09/29/21 revealed an order for docusate sodium (used for constipation) 100mg<br><br>Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for docusate sodium 100mg daily with a scheduled administration time of 8:00am.<br>-There was documentation that docusate sodium was administered daily at 8:00am from 01/01/22 to 01/31/22.<br><br>Review of Resident #6's February 2022 eMAR revealed:<br>-There was an entry for docusate sodium 100mg | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 23<br>daily with a scheduled administration time of 8:00am.<br>-There was documentation that docusate sodium was administered daily at 8:00am from 02/01/22 to 02/28/22.<br><br>Review of Resident #6's March 2022 eMAR revealed:<br>-There was an entry for docusate sodium 100mg daily with a scheduled administration time of 8:00am.<br>-There was documentation that docusate sodium was administered daily at 8:00am from 03/01/22 to 03/31/22.<br><br>Telephone interview with a representative from the facility's contracted pharmacy on 05/012/22 at 9:53am revealed:<br>-Docusate sodium was used to treat and prevent constipation.<br>-There was an order for docusate sodium 100mg daily dated 09/29/21.<br>-The pharmacy dispensed 30 tablets of docusate sodium 100mg on 01/27/22.<br>-The facility returned 30 of 30 tablets of docusate sodium 100mg on 03/07/22 that were dispensed on 01/27/22.<br>-The pharmacy dispensed 30 tablets of docusate sodium 100mg on 02/28/22. .<br><br>Based on eMAR documentation, medications dispensed and returned to the pharmacy between 01/27/22-03/07/22, there would have been no docusate sodium available to be administered from 01/27/22-02/27/22.<br><br>Attempted telephone interview with Resident #6's hospice provider on 05/12/22 at 10:00am was unsuccessful. | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 24<br><br>Refer to the interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm.<br><br>Refer to the interview with a medication aide (MA) on 05/12/22 at 1:45pm.<br><br>Refer to the telephone interview with the second shift supervisor on 05/12/22 at 10:00am.<br><br>Refer to the telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm.<br><br>Refer to the interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm.<br><br>Refer to the interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm.<br><br>Refer to the interview with the Administrator on 05/12/22 at 4:05pm.<br><br>_____<br>Interview with a representative from the facility's contracted pharmacy on 05/11/22 at 3:10pm revealed:<br>-The facility had been on auto-refill since February 2022; the pharmacy would automatically send a 30-day supply monthly.<br>-A resident would have extra pills when they refused medications or they were not in the facility during administration time of the medication; otherwise, there should be no extra pills with the 30-day supply.<br>-When medications needed to be returned to the pharmacy, the facility staff would complete a return to pharmacy form, including the name of the resident and medication, quantity of medication, and the prescription number.<br><br>Interview with a medication aide (MA) on | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 25<br>05/12/22 at 1:45pm revealed:<br>-She had always had all of Resident #6's scheduled medications to administer.<br>-She did not know why scheduled medications would be returned to the pharmacy.<br><br>Telephone interview with the second shift supervisor on 05/12/22 at 10:00am revealed:<br>-He returned medications to the pharmacy as needed.<br>-He would complete a return to pharmacy form when he prepared the medications to be sent back.<br>-He did not recall dispensed dates on the medications that were returned to the pharmacy.<br><br>Telephone interview with a second medications aide (MA) on 05/12/22 at 2:22pm revealed:<br>-Resident #6's medications were always on the medication cart for administration.<br>-She did not know why Resident #6 would have extra medications to be returned to the pharmacy.<br><br>Interview with the Memory Care Coordinator (MCC) on 05/12/22 at 2:03pm revealed:<br>-Medication carts were audited weekly by the MCC or Resident Care Coordinator (RCC).<br>-They looked for expired medications, pharmacy dispensed dates, and ensured medications are administered based on dispensed dates.<br>-The second shift supervisor returned medications to the pharmacy.<br>-She did not know why scheduled medications had been returned to the pharmacy.<br>-She did not recall pulling scheduled medications to be returned to the pharmacy.<br>-The pharmacy must have sent extra bubble packs of medications.<br>-It would appear the medications were not administered if they were returned to the | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 26<br>pharmacy.<br><br>Interview with the Health and Wellness Director (HWD) on 05/12/22 at 3:25pm revealed:<br>-The medication carts were audited weekly.<br>-The MCC and the HWD were primarily responsible for the medication cart audits; the MAs would assist as needed.<br>-She would audit the medication carts to ensure that medications were separated based on the route of administration, removed expired medications on the medication cart, all medications that were entered on the eMAR were located on the medication cart, removed as needed medications that had not been administered in three months and count pills in bubble pack and compare with administration of medication based on dispensed date from the pharmacy.<br>-The facility's contracted pharmacy sent five nurses on 03/03/22 to audit all medication carts and medication rooms.<br>-The removed several bottles of siltussin SA because it was not being used by Resident #6.<br>-The facility was on a monthly automatic refill for all scheduled medications.<br>-The second shift supervisor would receive the medications, place the medication on the medication cart, and remove the previous bubble pack.<br>-The second shift supervisor was responsible for returning medications to the pharmacy.<br>-The pharmacy had not wanted the facility to complete the return to pharmacy form since late March or early April.<br>-She did not know why there would be extra medications to be returned to the pharmacy unless the pharmacy sent an excess amount of medications.<br>-There were different MAs on the medication cart | {D 358} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| {D 358} | Continued From page 27<br>administering the medications; one of the MAs would have said something if the medication had not been there for administration.<br>-There should be exceptions documented if Resident #6 was out of the facility and not available during medication pass.<br><br>Interview with the Administrator on 05/12/22 at 4:05pm revealed:<br>-Resident #6 may have extra pills if he had been in the hospital or refused medications; the MAs would have documented exceptions for these reasons.<br>-She did not know why there would be extra medications returned to the pharmacy if Resident #6 had not been hospitalized or refused medications.<br>-She expected the MAs to administer medications as ordered to Resident #6.<br>-The facility only returned unused or discontinued narcotics to the pharmacy.<br>-The MA's would prepare the return to pharmacy form and a representative from the pharmacy would pick up medications that were to be returned to the pharmacy.<br>-All other medication should be destroyed in the facility by placing the medication in the drug buster.<br>-She did not know why the MAs were returning medications other than narcotics to the facility. | {D 358} | | |
| D 375 | 10A NCAC 13F .1005(a) Self-Administration Of Medications<br><br>10A NCAC 13F .1005 Self -Administration Of Medications<br>(a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 28<br>requirements are met:<br>(1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and<br>(2) specific instructions for administration of prescription medications are printed on the medication label.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 residents sampled (#8 and #9) had a physician's order to self-administer a sleep aide (#8) and a multi-vitamin supplement, an herbal supplement (#9).<br><br>The findings are:<br><br>Review of the facility's self-medication administration policy revealed:<br>-All residents had the right to self-administer medication if ordered by their physician but with parameters.<br>-Residents declared incompetent or incapacitated under the laws of the state could not self-administer their medications.<br>-Residents who resided on the memory care unit could not self-administer their medications.<br>-Any resident who desired to self-manage their medication must complete the self-administration assessment.<br>-The Health and Wellness Director (HWD) was responsible for completing the self-administration assessment.<br>-The HWD would report the results of the self-administration assessment to the physician | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 29<br>and the physician and HWD made the final determination of the resident's ability to self-administer medications.<br>-A written physician's order was required to be maintained in the resident's record and updated as needed/required.<br><br>1. Review of Resident #8's current FL-2 dated 03/10/22 revealed:<br>-Diagnoses included insomnia, depression, hypertension, vitamin D deficiency, osteoporosis, and dementia.<br>-There was no order for melatonin (used for short term treatment of difficulty sleeping).<br>-There was no order to self-administer medications.<br><br>Interview with Resident #8 on 05/10/22 at 10:43am revealed:<br>-She kept a bottle of melatonin tablets in her room.<br>-She stored the bottle of melatonin in her drawer because she wanted to prevent any other resident from obtaining the bottle.<br>-She used melatonin if she could not fall asleep within one hour of going to bed.<br>-She took one melatonin to help her sleep only if she could not fall asleep after one hour at night.<br>-She did not know if her primary care provider (PCP) knew that she was taking melatonin.<br>-She did not know if she had an order from her PCP for melatonin.<br>-She had told her PCP that she had difficulty sleeping.<br><br>Observation of the second drawer of Resident #8's dresser on 05/11/22 at 4:37pm revealed:<br>-A bottle of melatonin 5mg tablets with lemon balm; there was one opened bottle.<br>-The pill bottle indicated 240 tablets were in an | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 30<br>unopened bottle of melatonin.<br><br>Review of Resident #8's care plan dated 05/27/21 revealed there was documentation that staff were to administer all medications.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/11/22 at 9:25am revealed:<br>-Resident #8 did not have an order for melatonin.<br>-Resident #8 did not have an order to self-administer medications.<br><br>Telephone interview with Resident #8's PCP on 05/12/22 at 9:00am revealed:<br>-He had not written a self-administration of medications order for Resident #8.<br>-Resident #8 should not have melatonin in her room.<br>-He had not ordered melatonin for Resident #8.<br>-Resident #8 had told him she had difficulty sleeping and he prescribed trazodone.<br>-Resident #8 could not self-administer her medications because she had a diagnosis of dementia.<br><br>Interview with a medication aide (MA) on 05/12/22 at 9:37am revealed:<br>-He did not know Resident #8 had medications in her room.<br>-Resident #8's family took her out and the resident would be able to purchase things that the staff would not necessarily know about.<br>-Resident #8 did not have an order to self-administer medications.<br><br>Interview with the Resident Care Coordinator (RCC) on 05/12/22 at 10:22am revealed:<br>-She did not know Resident #8 had medications in her room. | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 31<br>-Resident #8 did not have any orders to self-administer medications.<br><br>Interview with the Health Wellness Director (HWD) on 05/12/22 at 10:46am revealed:<br>-She did not know Resident #8 had a bottle of melatonin in her room.<br>-Resident #8 did not have a self-administration of medication order.<br><br>Interview with the Administrator on 05/12/22 at 1:55pm revealed she did not know Resident #8 had medications in her room to self-administer.<br><br>Refer to the interview with the RCC on 05/12/22 at 10:22am.<br><br>Refer to the interview with the HWD on 05/12/22 at 10:46am.<br><br>Refer to the interview with the Administer on 05/12/22 at 1:55pm.<br><br>2. Review of Resident #9's current FL-2 dated 03/10/22 revealed<br>-Diagnoses included dementia, multiple myeloma, chronic pain disorder, hyperlipidemia and chronic kidney disease.<br>-There was no medication order for ginkgo-biloba (an alternative medication used to aid mental function).<br>-There was an order for daily-vite (used to treat vitamin deficiency) one tablet daily.<br>-There was no order to self-administer medications.<br><br>Interview with Resident #9 on 05/10/22 at 10:28am revealed:<br>-She purchased the bottle of multi-vitamins and the bottle of ginkgo-biloba when she went | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 32<br>shopping.<br>-She did not recall when he last used the medication.<br>-She took one tablet multi-vitamin and one tablet of ginkgo-biloba when she remembered to take them.<br>-She had memory changes and did not always remember to take the medication.<br>-She did not know if her primary care provider knew she took her own multi-vitamins or the ginkgo-biloba.<br><br>Observation of Resident #9's room on 05/10/22 at 10:28am revealed a bottle of multi-vitamins and a bottle of ginkgo-biloba were setting beside Resident #9's television on top of a console.<br><br>Review of Resident #9's care plan dated 07/02/21 revealed there was documentation that the mediation aides were to administer Resident #9's medications.<br><br>Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/11/22 at 9:25am revealed:<br>-Resident #9 did not have an order to self-administer daily-vite or another multi-vitamin.<br>-He was concerned that Resident #9 was taking a duplicate medication, the multi-vitamin.<br>-Resident #9 did not have an order to self-administer ginkgo-biloba and Resident #9 had no order for ginkgo biloba.<br><br>Telephone interview with Resident #9's PCP on 05/12/22 at 9:00am revealed:<br>-He did not know Resident #9 had multi-vitamins in her room that she was self-administering.<br>-He thought he had ordered a daily multi-vitamin for Resident #9 so she did not need to self-administer a multi-vitamin. | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 33<br>-He did not know Resident #9 had ginkgo-biloba in her room that she was self-administering.<br>-He had not provided a self-administration of medications order for Resident #9.<br>-Resident #9 could not self-administer her medications due to a diagnosis of dementia.<br><br>Interview with a medication aide (MA) on 05/12/22 at 9:37am revealed:<br>-Resident #9 did not have an order to self-administer medications.<br>-He administered medications to Resident #9.<br>-He did not know Resident #9 had multi-vitamins and ginkgo-biloba in her room.<br><br>Telephone interview with the Resident Care Coordinator (RCC) on 05/12/22 at 10:22am revealed:<br>-She did not know Resident #9 had multi-vitamins and ginkgo-biloba in her room.<br>-Resident #9 did not have an order to self-administer medications.<br><br>Interview with the Health and Wellness Director (HWD) on 05/12/22 at 10:46am revealed:<br>-She did not know Resident #9 had multi-vitamins and ginkgo-biloba in her room.<br>-Resident #9 did not have an order to self-administer medications.<br><br>Interview with the Administrator on 05/12/22 at 1:55pm revealed she did not know Resident #9 had medication in her room to self-administer.<br><br>Refer to the interview with the RCC on 05/12/22 at 10:22am.<br><br>Refer to the interview with the HWD on 05/12/22 at 10:46am. | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 34<br>Refer to the interview with the Administer on 05/12/22 at 1:55pm.<br>_____<br>Telephone interview with the RCC on 05/12/22 at 10:22am revealed:<br>-Residents who self-administered medications had to have a physician order.<br>-The HWD completed a test to determine if the resident was capable of self-administering medications.<br>-If she observed medications in a resident's room whom did not have a self-administration of medications order she removed the medications.<br>-She would first communicate with the resident in a respectful manner explaining why the medication could not remain in the room.<br>-She would check the resident's orders to determine if there was a physician order to self-administer the removed medication.<br>-If the resident did not have an order, she would notify the physician, the HWD and the resident's family member.<br>-The MAs were responsible for ensuring residents without an order to self-administer medications did not have medications in their rooms.<br><br>Interview with the HWD on 05/12/22 at 10:46am revealed:<br>-When residents had an order to self-administer medications, residents administered their medication.<br>-If a resident did not have an order to self-administer medication, then there should be no medication in the resident's room.<br>-Upon admission residents told her if they wanted to self-administer medications.<br>-She completed an assessment to determine if the resident was capable of self-administering medications. | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 35<br>-She expected staff to remove medications that were discovered in residents' rooms without an order to self-administer medications.<br>-She was ultimately responsible for ensuring residents who self-administered medications had a physician order.<br><br>Interview with the Administrator on 05/12/22 at 1:55pm revealed:<br>-Residents had to have an order to self-administer any medication kept in their room.<br>-The HWD had to complete a quarterly assessment for residents with an order to self-administer medications.<br>-She expected staff to contact a resident's power of attorney and PCP to discuss self-administration orders and follow the recommendations provided by the PCP.<br>-She held the HWD and MAs responsible for ensuring residents without a self-administration of medications order did not have medications in their rooms. | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 33<br><br>-He did not know Resident #9 had ginkgo-biloba in her room that she was self-administering.<br>-He had not provided a self-administration of medications order for Resident #9.<br>-Resident #9 could not self-administer her medications due to a diagnosis of dementia.<br><br>Interview with a medication aide (MA) on 05/12/22 at 9:37am revealed:<br>-Resident #9 did not have an order to self-administer medications.<br>-He administered medications to Resident #9.<br>-He did not know Resident #9 had multi-vitamins and ginkgo-biloba in her room.<br><br>Telephone interview with the Resident Care Coordinator (RCC) on 05/12/22 at 10:22am revealed:<br>-She did not know Resident #9 had multi-vitamins and ginkgo-biloba in her room.<br>-Resident #9 did not have an order to self-administer medications.<br><br>Interview with the Health and Wellness Director (HWD) on 05/12/22 at 10:46am revealed: | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 34<br>Refer to the interview with the Administer on 05/12/22 at 1:55pm.<br>_____<br>Telephone interview with the RCC on 05/12/22 at 10:22am revealed:<br>-Residents who self-administered medications had to have a physician order.<br>-The HWD completed a test to determine if the resident was capable of self-administering medications.<br>-If she observed medications in a resident's room whom did not have a self-administration of medications order she removed the medications.<br>-She would first communicate with the resident in a respectful manner explaining why the medication could not remain in the room.<br>-She would check the resident's orders to determine if there was a physician order to self-administer the removed medication.<br>-If the resident did not have an order, she would notify the physician, the HWD and the resident's family member.<br>-The MAs were responsible for ensuring residents without an order to self-administer medications did not have medications in their rooms.<br><br>Interview with the HWD on 05/12/22 at 10:46am revealed:<br>-When residents had an order to self-administer medications, residents administered their medication.<br>-If a resident did not have an order to self-administer medication, then there should be no medication in the resident's room.<br>-Upon admission residents told her if they wanted to self-administer medications.<br>-She completed an assessment to determine if the resident was capable of self-administering medications. | D 375 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL032133 | A. BUILDING: _____ B. WING _____ | R 05/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE ADDISON OF DURHAM | 4713 GARRETT ROAD DURHAM, NC 27707 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| D 375 | Continued From page 35<br>-She expected staff to remove medications that were discovered in residents' rooms without an order to self-administer medications.<br>-She was ultimately responsible for ensuring residents who self-administered medications had a physician order.<br><br>Interview with the Administrator on 05/12/22 at 1:55pm revealed:<br>-Residents had to have an order to self-administer any medication kept in their room.<br>-The HWD had to complete a quarterly assessment for residents with an order to self-administer medications.<br>-She expected staff to contact a resident's power of attorney and PCP to discuss self-administration orders and follow the recommendations provided by the PCP.<br>-She held the HWD and MAs responsible for ensuring residents without a self-administration of medications order did not have medications in their rooms. | D 375 | | |